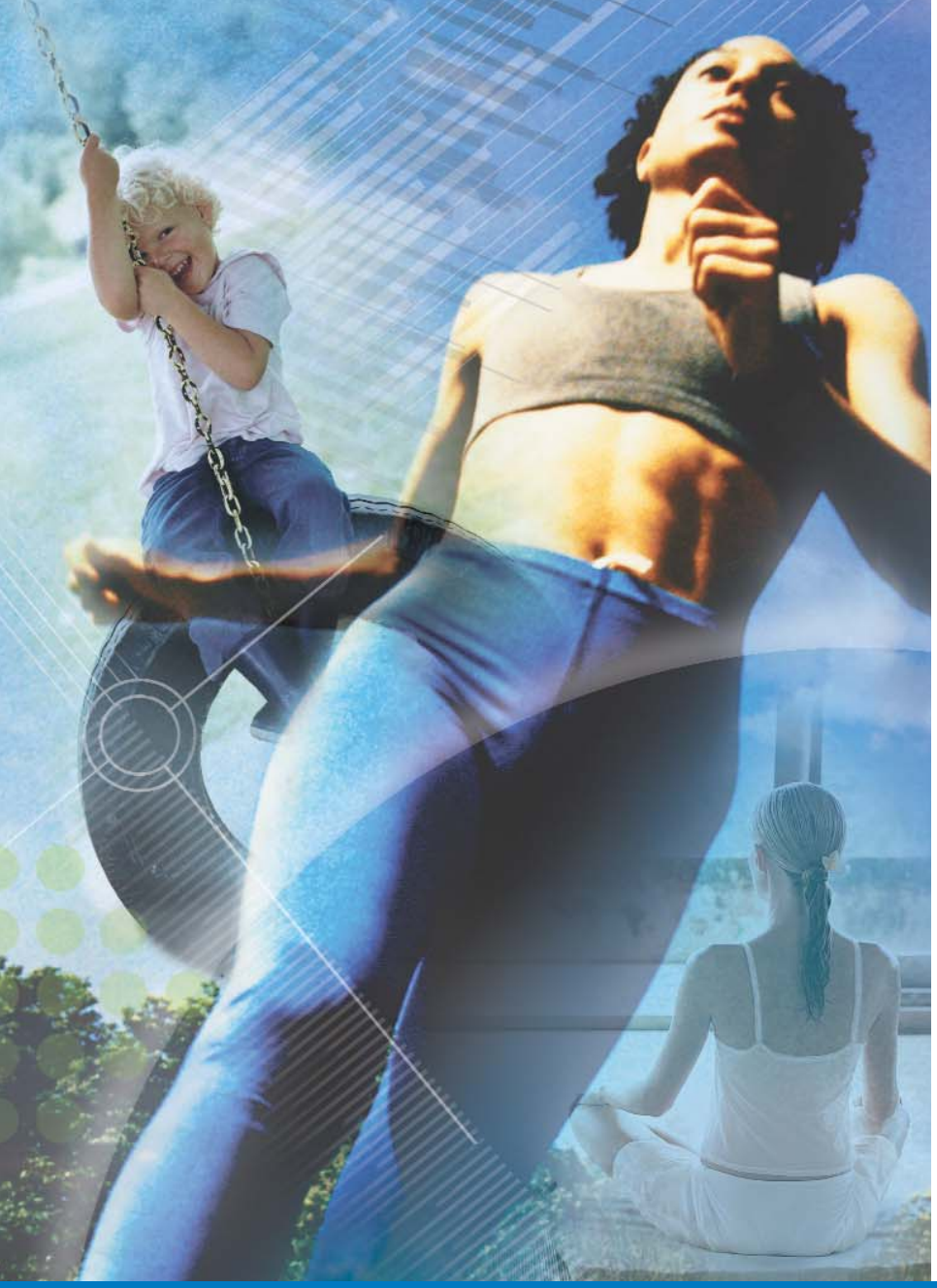

Anthem

Stafford County Public Schools

Effective July 1, 2005

Anthem KeyCare

anthem.com

Anthem KeyCare members have the right to privacy and that right is respected by all Anthem Blue Cross and Blue Shield employees. We abide by the Commonwealth of Virginia Privacy Protection Act and have procedures in place to ensure your privacy. Any medical information we receive about Anthem KeyCare members, including medical records from health care professionals or hospitals, will be kept confidential and, except as permitted by law, will not be made available without the member's written permission. In a limited number of situations, Anthem Blue Cross and Blue Shield may need to release confidential information without written authorization (but within the law) in order to administer benefits – for example, conducting coordination of benefits between health care carriers. Anthem KeyCare members can review any personal information collected about them by Anthem Blue Cross and Blue Shield including medical records held by us by calling Member Services. Corrections to inaccurate information will be made at their request.

The confidentiality of Anthem KeyCare members' medical records is not just protected by law; Anthem Blue Cross and Blue Shield goes beyond the law's requirements to ensure privacy. All our employees are required to sign confidentiality statements keeping member records private, and by contract, members' employers are required to protect their records and are prohibited from misusing confidential information. Anthem Blue Cross and Blue Shield also contractually requires network health care professionals to keep member medical records confidential. Any medical information received on our members' behalf is kept secure and access to this information is limited to approved employees.

Anthem Blue Cross and Blue Shield operates Anthem KeyCare as a managed care health insurance plan ("called an MCHIP") subject to regulation in the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 of the Virginia Code and the Virginia Department of Health pursuant to Title 32.1 of the Virginia Code.

How coverage is determined

Your Anthem KeyCare plan only covers medically necessary services. To be considered medically necessary, a service must be required to identify or treat an illness, injury, or pregnancy-related condition; be consistent with the symptoms or diagnosis and treatment of your condition; be in accordance with standards of generally accepted medical practice; and be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the provider. In addition, when a medically necessary service can be performed safely in a number of different settings, for example in a doctor's office, in a hospital outpatient department or as an inpatient, it will be covered when performed in the least costly of these settings. Knowing how your benefits apply to your treatment alternatives, you and your doctor can make an informed, final decision about your care that's the right decision for you.

In-Network Services

Anthem KeyCare is offered by Anthem Blue Cross and Blue Shield

Description For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit (whether received in-network or out-of-network) are applied to that limit.	Current KeyCare Plan YOU PAY	KeyCare 15 YOU PAY	KeyCare 30 YOU PAY
Deductible – The amount you need to pay for in-network services in one calendar year before you pay the amounts listed below.	**$100** (per person) **$200** (per family)	**None**	**$1,000** (per person) **$2,000** (per family)
Sick visits • office visits • urgent care visits	**20%**	**$15** for each visit to a family or general practitioner, internist or pediatrician **or** **$30** for each visit to a specialist	**$30** for each visit to a health care professional
Routine wellness • an annual checkup • well baby checkups • an annual mammogram for members age 35 and older • an annual wellness checkup visit for members age 7 and older • an annual gynecological exam • Pap tests • an annual Prostate Specific Antigen (PSA) test for men age 40 and older • prostate exams • immunizations • screening tests for children under age 7 • labs and x-rays related to routine wellness services • colorectal cancer screenings **Plus** Up to $150 per calendar year for family members age 6 and older for additional routine immunizations, and all other routine labs and x-rays done in connection with annual wellness checkups. • We will pay 100% of the cost for labs, and immunizations until the amount paid by us reaches $150. • Then, you will pay 100% of the cost of the additional immunizations, labs and x-rays done as part of an annual checkup. The costs of the annual mammogram, Pap, PSA and colorectal cancer screening tests will not count toward this $150 of additional coverage.	**No charge**	**$15** for each visit to a family or general practitioner, internist or pediatrician **or** **$30** for each visit to a specialist for exams and immunizations **20%** for labs, x-rays and screenings **$100 plus 20%** for facility-based colorectal cancer screenings	**$30** for each visit to a health care professional for exams and immunizations **20%** for labs, x-rays and screenings and colorectal cancer screenings
Maternity care • Pre and post-natal care	**No charge**	**$15** for each visit to a family or general practitioner, internist or pediatrician **or** **$30** for each visit to a specialist	**$30**
• Inpatient hospital stay	**No charge**	**$300 plus 20%**	**20%** subject to deductible

This document contains highlights of the plans you are being offered by Anthem Blue Cross and Blue Shield. Please refer to your benefit booklet for full details on plan provisions.

Anthem KeyCare

Anthem KeyCare is offered by Anthem Blue Cross and Blue Shield

Description For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit (whether received in-network or out-of-network) are applied to that limit.	Current KeyCare Plan YOU PAY	KeyCare 15 YOU PAY	KeyCare 30 YOU PAY
Emergency care as an outpatient in a hospital or facility			
• accidental injury-related emergency room visits	**No charge**	**$100 Plus 20%**	**20%** subject to deductible
• other emergency room visits	**20%** subject to deductible	**$15** for each visit to a family or general practitioner, internist or pediatrician **or** **$30** for each visit to a specialist	**20%** subject to deductible
• day surgery as an outpatient in a hospital or facility	**No charge**	**$100 Plus 20%**	**20%** subject to deductible
• outpatient surgery			
facility charges	**No charge**	**$100 Plus 20%**	**20%** subject to deductible
physician services **Depending on the type of doctor who treats you*	**No charge**	**$15*** or **$30**	**20%** subject to deductible
Therapy visits as an outpatient in a hospital or facility			
• physical therapy and occupational therapy • speech therapy • spinal manipulations and other manual medical intervention visits ($500 maximum)	**20%** subject to deductible	**$30 Plus 20%**	**20%** subject to deductible
Mental health and substance abuse			
• outpatient visits	**20%** subject to deductible	**$15** for each visit to a family or general practitioner, internist or pediatrician **or** **$30** for each visit to a specialist	**$30** for each visit to a health care professional
• inpatient admissions			
facility charges	**No charge**	**$300 Plus 20%**	**20%** subject to deductible
physician services	**No charge**	**20%**	**20%** subject to deductible
Care at home			
• home health care visits by a nurse or aide • hospice care	**No charge**	**No charge**	**20%** subject to deductible
• private duty nursing **Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.*	**20%*** subject to deductible	**20%***	**20%*** subject to deductible

In-Network Services

Anthem KeyCare is offered by Anthem Blue Cross and Blue Shield

Description For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit (whether received in-network or out-of-network) are applied to that limit.	Current KeyCare Plan YOU PAY	KeyCare 15 YOU PAY	KeyCare 30 YOU PAY
Inpatient stays in a network hospital or facility			
• semi-private room, intensive care or similar unit	**No charge**	**$300 Plus 20%**	**20%** subject to deductible
• physician, nursing and other professional services in the hospital	**No charge**	**20%**	**20%** subject to deductible
• medically necessary services including anesthesia, operating room, delivery room	**No charge**	**20%**	**20%** subject to deductible
• skilled nursing facility care (100 days for each admission)	**No charge**	**20%**	**20%** subject to deductible
Other covered services			
• professional ground ambulance services	**20%** subject to deductible	**20%**	**20%** subject to deductible
• durable medical equipment	**20%** subject to deductible	**20%**	**20%** subject to deductible
• diabetic-related supplies, equipment and education	**20%** subject to deductible	**20%**	**20%** subject to deductible
• shots and therapeutic injections	**20%** subject to deductible	**20%**	**20%** subject to deductible
• medical appliances and supplies	**20%** subject to deductible	**20%**	**20%** subject to deductible
• chemotherapy, IV, radiation and respiratory therapy	**20%** subject to deductible	**20%**	**20%** subject to deductible
• outpatient diagnostic labs and X-rays (not related to wellness)	**No charge**	**20%**	**20%** subject to deductible
Routine vision			
• annual eye exam	**$15**	**$15**	**$15**
Plus valuable discounts through Davis Vision on:			
• eyewear (up to 40% off)			
• laser vision correction surgery (up to 25% off)			
• contact lens fittings (up to 15% off)			
Prescription coverage			
For retail prescriptions up to a 31-day supply, you will pay the dollar amount or percentage amount, whichever is greater.	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd
• **Retail**	**$8 $15 $30**	**$10 $20 $35**	**$10 $20 $35**
• **Mail Order**	**$16 $30 $60**	**$20 $40 $70**	**$20 $40 $70**

Anthem KeyCare

Anthem KeyCare is offered by Anthem Blue Cross and Blue Shield

Description
For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit (whether received in-network or out-of-network) are applied to that limit.

	Current KeyCare Plan	KeyCare 15	KeyCare 30
	YOU PAY	YOU PAY	YOU PAY
Using doctors, hospitals and other health care professionals not contracted to provide benefits It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this benefits overview chart until you have met your plan's out-of-network amount (listed to the right).	**$100** (per person) **$200** (per family)	**$400** (per person) **$800** (per family)	**$1,500** (per person) **$3,000** (per family)
Once you have reached this amount, when you receive covered services we will pay a percentage of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will reimburse you $30 (whether or not you have reached your out-of-network deductible), and you will pay the rest of what the professional charges.	**30%**	**30%**	**40%**

What you will pay for covered services in one calendar year (January 1 to December 31)	Current KeyCare Plan	KeyCare 15	KeyCare 30
The following do not count toward the calendar year payment limit. You will still need to pay: • your share of the cost of care received in hospitals and other facilities that do not have an agreement with us or another Blue Cross and Blue Shield plan • your share of the cost of prescription drugs and routine vision care • the cost of care received when the benefit limits have been reached • the cost of services and supplies not covered under your Anthem plan • the additional amount health care professionals not in our network may bill you when their charge is more than what we pay	**When using network professionals** If you are the only one covered by your plan, you will pay the amounts listed below for covered services outlined in this benefits overview chart. Once you have reached this amount, your payment for covered services is $0, except for services listed to the left. **$1,000** (per person) **$2,000** (per family)	**$2,000** (per person) **$4,000** (per family)	**$3,000** (per person) **$6,000** (per family)
	When not using network professionals If you are the only one covered by your plan, you will pay the amounts listed below for covered services outlined in this benefits overview chart. Once you have reached this amount, your payment for covered services is $0, except for services listed to the left. **$1,500** (per person) **$3,000** (per family)	**$4,000** (per person) **$8,000** (per family)	**$4,500** (per person) **$9,000** (per family)

Health and Wellness Resources

Do you have a plan for good health? With Anthem KeyCare, you do.

Your Anthem KeyCare plan gives you:

coverage for important health care services including:

- well and sick visits
- labs, x-rays and other types of tests
- emergency and urgent care
- annual routine eye exams through Davis Vision
- maternity visits before and after having a baby
- care in a hospital

a team of doctors, nurses and other health care professionals who can:

- be there for you when you're sick
- help you make smart lifestyle choices to be in the best health you can
- take the time to listen to your concerns and answer your questions

access to discounts on:

- health and wellness products
- fitness clubs and health centers
- alternative medicine services
- vitamins and nutritional supplements
- eyewear and supplies
- laser vision correction surgery through Davis Vision
- programs that can help you become smoke-free

Anthem KeyCare

With Anthem KeyCare, you can choose a doctor across the street or across the country.

Anthem KeyCare members can choose to receive services from any doctor, hospital or other health care professional.

Those with an agreement to serve Anthem KeyCare members

Doctors, hospitals and other health care professionals with an agreement to serve members are also known as "network" professionals. When you become an Anthem KeyCare member, your identification card will carry the Cross and the Shield, two symbols that can expand your network of doctors, hospitals and other health care professionals to include all those affiliated with Blue Cross and Blue Shield KeyCare plans across the country and throughout the world! With participating professionals all across America, there's a good chance the doctors you currently see are part of the network.

Using network doctors, hospitals and other health care professionals has its advantages. These network professionals have agreed to accept set fees as payment for their services. Plus, they will file claim forms and handle any authorizations for you.

Those without an agreement to serve Anthem KeyCare members

You can use doctors, hospitals and other health care professionals that don't have agreements to serve Anthem KeyCare members. These professionals are often called "out-of-network." There are doctors, hospitals and other health care professionals that do not have agreements to serve members in Anthem KeyCare plans but do have agreements with us or other Blue Cross and Blue Shield plans to serve members in our other health plans. While these professionals are still considered "out-of-network" for Anthem KeyCare members, they will accept set fees as payment for their services.

Professionals that do not have any agreements with us or other Blue Cross and Blue Shield plans can charge whatever they want for their services. Typically, when you receive covered services from these out-of-network doctors, hospitals and other health care professionals, we will pay a set percentage of the amount we pay doctors, hospitals and other health care professionals that have an agreement with us for the same service. **You will pay the rest.** If what these out-of-network professionals charge is more than what we pay, they can bill you for the difference between the two amounts. Payments to out-of-network professionals will never be more than what we would have paid to a participating provider.

Services that require advance reviews

Network doctors, hospitals and other health care professionals will work with us to make sure certain procedures and services are reviewed to see if they can be covered under your Anthem KeyCare plan. This "prior authorization" is done for stays in a hospital or a skilled nursing facility and for all outpatient mental health and substance abuse care as well.

If you're not using a network professional, you need to work with us to complete your hospital admission review before your inpatient stay. If you are admitted to the hospital directly from the emergency room, you (or someone on your behalf) need to contact us within 48 hours of your admission. You should also call us to get prior authorization for outpatient mental health and substance abuse services you want to receive from a doctor, hospital or other health care professional that doesn't participate with Anthem Blue Cross and Blue Shield.

Health care coverage when you need it — at home or on the road

When you are an Anthem KeyCare member, your identification card carries the Cross and the Shield — two symbols that can help make seeking services under your health plan easy, no matter where you are. There are affiliated Blue Cross and Blue Shield plans across the United States that combine to participate in the BlueCard PPO program. Almost all Anthem KeyCare members can use this network of doctors, hospitals and other health care professionals. In the event you receive services in a state with more than one Blue plan network, an exclusive network may be in place. You may call Member Services or go to anthem.com for information regarding such networks. You also have the health care coverage you need while living or traveling outside of the United States. An extension of the BlueCard program, BlueCard Worldwide®, enab les KeyCare members to obtain medical assistance and inpatient, outpatient and professional services from a network of health care providers worldwide. BlueCard Worldwide provides international healthcare management, a global network of providers and a Web site with travel health information — at no additional cost. The BlueCard® PPO program is not available to Point of Service members.

Anthem KeyCare

Emergency care

An *emergency* is the sudden onset of a medical condition with such severe symptoms that a person with an average knowledge of health and medicine (also called a "prudent lay person") would seek medical care immediately because there may be:

- serious risk to mental or physical health
- danger or significant impairment of body functions
- significant harm to organs in the body (heart, brain, kidneys, liver, lungs, etc.)
- danger to the health of the baby in a pregnant woman

If you ever need emergency medical care as described above, go immediately to the nearest medical facility. Emergency care is covered no matter where the services are received. You (or someone on your behalf) should call us within 48 hours after receiving emergency care services.

Anthem KeyCare Deductible Plans

If your plan includes a deductible requirement, covered services that are received during the last three months of the calendar year may also be applied to the deductible required for the following year.

When you're admitted to the hospital or skilled nursing facility.

Isn't it good to know that while you're an inpatient in the hospital or skilled nursing facility, you have an entire team working on your behalf? Made up of your doctor, the nurses and discharge planners at the hospital or skilled nursing facility and the Anthem KeyCare doctors and nurses on our staff, the Helping You Home®| team is working to help make sure you get the right care in the right place at the right time.

Before you go to the hospital or skilled nursing facility…

Your team is involved in your care from the start and are the ones who discuss the need for you to be admitted to a hospital or skilled nursing facility (called "prior authorization"). With advances in technology, many medical procedures that once could only be done in a hospital can be done safely in a doctor's office or as day surgery in an outpatient setting.

While you're there…

Once you're admitted to a hospital or skilled nursing facility, the Helping You Home team focuses on the care you're receiving while you're an inpatient. The nurses and doctors make sure you're getting the right services for your condition, and just as important, make sure you're not going through unnecessary procedures. This phase is called "concurrent review" and tracks the progress you're making while you're still in the hospital or skilled nursing facility.

When you leave…

When it's time for you to leave the hospital or skilled nursing facility, the Helping You Home team has finalized the plan that can help you make a smooth transition back home. They can even help coordinate the services you'll need once you're ready to leave, whether or not they are covered under your Anthem KeyCare plan. Some of the factors considered by your team include:

- Do you need a specialized van to take you home or can a family member drive you?
- Do you need a hospital bed at home?
- Will you need home visits by a nurse?
- Do you need crutches, a walker or any other type of durable medical equipment?
- Will bandages need to be changed? Will you need a medical professional to do it or can you change them yourself?

Anthem KeyCare

Expecting a baby?

Going to the doctor as soon as you suspect you're pregnant and continuing to get checkups and wellness visits throughout your pregnancy is the best way to start off your baby's life. Having good, reliable information about what to expect during the pregnancy and after the baby is born is important as well.

Baby Benefits, a prenatal program that accompanies your Anthem KeyCare plan and is administered by our affiliated company, Health Management Corporation, involves your entire family with the pregnancy by providing information for the expectant mother, father and the rest of the family members. Your family will also be able to use the services of a specialized team of obstetric nurses, on-call for you 24 hours a day. These specially-trained nurses will work with you and your doctors to help prevent premature births and make sure the pregnancy is the healthiest possible. You'll also receive a congratulatory baby gift once your baby's born.

Visit us online

Anthem.com is your resource for the health care answers you need.

Need to know which plan is right for you?

Explore the Coverage Advisor to predict your health care expenses — before they occur. It's easy, confidential, and can help you determine the coverage that's right for you.

Member self-service

- Update your personal information.
- Determine the status of your claims or download them for your records.
- Use our secure message center to submit any questions you have about your coverage.
- Lost your ID card? Order a new one here.

Hospital comparison

- Discover how your hospital compares for procedures performed, complication rates and critical resources, such as intensive care units and the latest technology.

Treatment decision guide

- Explore what you need to know to make the most informed decisions about your health — including the questions to ask your doctor, treatment options, community resources and issues to consider.

Answers@Anthem

- Search the provider directory for doctors, and even get driving directions to their office.
- Get up to speed on the medicines you take, their typical cost, alternative medications that may work just as well for less money out of your pocket, and information about interactions with other medicine you may be taking.

Plus…

- Use ***Cool Tools*** for interactive learning on everything from your child's adult height predictor to how much your smoking habit really costs you.
- Find help for that nagging backache through the ***Medical Library*** that covers over 2,500 topics.
- Feel like your treadmill's getting you nowhere? Check out the ***Fitness & Nutrition*** section to find an exercise plan that will help you meet your goals.
- Take advantage of member discounts on fitness clubs, weight loss programs, smoking cessation tools and phone support services, and more through ***SpecialOffers@Anthem***.

Go to: Anthem.com ▶ Members ▶ Virginia

Health and Wellness Resources

Keep up with the latest health news

You'll be right on top of the latest health and wellness news with the *Anthem HealthNews* newsletter. Mailed to your home four times a year and available online at www.anthem.com, the articles and information can help you make smart decisions about your health care.

Living with asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD) or coronary artery disease?

Through Better Prepared℠ you can partner with specialized registered nurses who will answer any questions you have, give you information on the latest treatments available and work with your doctor to coordinate your health care services and resources. Better Prepared is administered through our affiliated company, Health Management Corporation.

Access to wellness programs and discount services

Your Anthem KeyCare plan covers a wide range of benefits to help you be as healthy as possible. Living a healthy lifestyle and knowing how to make smart lifestyle choices can often improve health and are two of the reasons why your Anthem KeyCare plan gives you access to discount services in addition to health and wellness programs.

Please note that the discount services listed within this brochure and the *Anthem Healthy Solutions* are not covered as benefits or guaranteed under your Anthem KeyCare plan and can be discontinued at any time.

Health and wellness resources

- access to doctors, hospitals and other health care professionals from coast to coast
- a team of doctors, nurses and other health care professionals working on your behalf
- access to discounts on alternative medicine services, health clubs, fitness centers
- access to prenatal programs
- a quarterly newsletter

Your Anthem KeyCare plan provides access to programs and discount services to expand your wellness resources.

Anthem KeyCare

Your Anthem KeyCare plan has a focus on health and wellness.

Coverage when you're feeling good...

You don't have to wait to be sick or injured before using your Anthem KeyCare plan. In fact, you have coverage for services that you can use when you're feeling fine. Your Anthem KeyCare coverage includes a wide range of wellness services in addition to preventive care and screenings:

- well baby visits, including recommended immunizations and tests
- an annual checkup
- an annual mammogram for members age 35 and older
- an annual gynecological exam for women (including a breast exam, pelvic exam and Pap test performed by any FDA-approved gynecological cytology screening technologies)
- prostate exams and an annual Prostate Specific Antigen (PSA) test for men age 40 and older
- colorectal cancer screenings (an annual fecal occult blood test, a barium enema, a flexible sigmoidoscopy or a colonoscopy in accordance with age, family history and frequency recommendations of the American College of Gastroenterology in consultation with the American Cancer Society)
- immunizations and other labs and x-rays done in connection with an annual checkup
- an annual routine eye exam through Davis Vision
- outpatient maternity care throughout pregnancy

...and when you are not

When you aren't feeling good or are injured — even if you think it's minor — you can count on your Anthem KeyCare coverage. Some of the services covered by your plan include:

- office visits
- diagnostic tests, labs and x-rays
- shots and injections
- physical, speech and occupational therapy
- surgery
- stays in a hospital or skilled nursing facility
- home health care services
- ambulance services
- medical equipment, supplies and appliances
- emergency care

Your Benefits and Discount Services

Healthy starts

Your Anthem KeyCare plan can help the youngest members of your family get off to the healthiest start possible. Coverage for well visits, immunizations and screenings is based on the recommendations of the American Academy of Pediatrics as well as those prescribed by Virginia's Commissioner of Health for children through age 6 including:

Childhood Immunizations

DTP (Diphtheria, Tetanus, Pertussis)
Polio
HIB (Hemophilus Influenza B)
Hepatitis B
MMR (Measles, Mumps, Rubella)
Pneumococcal Conjugate
Varicella (Chicken Pox)

Childhood Screening Tests

Blood tests (HGB/HCT/FEP)
Urine tests
Tuberculin tests
Pure tone audiogram tests
Machine vision tests
Testing for congenital adrenal hyperplasia
Infant hearing screenings and other audiological exams

While these immunizations can provide a good foundation for health, some children will need special services during the first years of their lives. Children up to age 3 who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (referred to as "DMH") as eligible under Part H of the Individuals with Disabilities Education Act are covered for early intervention services. These services are designed to help children reach or retain function so they are on a similar level with other children their age and include speech and language therapy, occupational therapy, physical therapy as well as assistive technology services and devices. These early intervention services are limited to a combined maximum of $5,000 per calendar year and the amount you pay is determined by the service received.

Tailor your wellness package

Members age 7 and older can work with their doctors to develop a preventive care and wellness plan personalized for their needs. Coverage includes:

- an annual checkup
- an allowance for immunizations, labs and x-rays done in connection with the annual checkup
- an annual gynecological exam
- an annual mammogram for members 35 and older
- an annual PSA test and prostate exams for men 40 and older
- colorectal cancer screenings

Your benefits and discount services

- preventive care and wellness benefits
- an annual routine eye exam
- office visits
- diagnostic services
- inpatient care
- emergency care
- discounts on eyewear and laser vision correction surgery

Routine eye exam

To receive your annual routine eye exam for $15, you need to use an eye care professional in the Davis Vision network. You can use eye care professionals outside of the Davis Vision network for the annual routine eye exam, but you will pay more.

An eye on savings

Visit Davis Vision network providers for discounts of up to 25% on laser vision correction surgery as well as discounts on eyewear.

Your Prescription Plan

Your copayments

Prescription drugs are divided into three categories, first, second and third tier.

For medications you need when you are not in a hospital, you can receive...	First Tier *Typically generic drugs* You Pay	Second Tier *Typically lower cost brand-name drugs* You Pay	Third Tier *Typically higher cost brand-name drugs* You Pay
Up to a 31-day medication supply from participating retail pharmacies	$8 (current KeyCare Plan) $10 (KeyCare 15 or KeyCare 30 plan)	$15 (current KeyCare Plan) $20 (KeyCare 15 or KeyCare 30 plan)	$30 (current KeyCare Plan) $35 (KeyCare 15 or KeyCare 30 plan)
Up to a 90-day medication supply through the Anthem RX Direct Mail Pharmacy	$16 (current KeyCare Plan) $20 (KeyCare 15 or KeyCare 30 plan)	$30 (current KeyCare Plan) $40 (KeyCare 15 or KeyCare 30 plan)	$60 (current KeyCare Plan) $70 (KeyCare 15 or KeyCare 30 plan)

Hassle-free prescriptions

Getting prescriptions filled is easy when you present your Anthem Blue Cross and Blue Shield identification card to a participating pharmacist.

1. Present your card and your prescription to your participating pharmacist.
2. The pharmacist will tell you your payment responsibility (and it's typically a fraction of the full retail price of the drug!)
3. Receive your prescription and be on your way.

Your choice

You can receive your prescription in one of the following ways:

- **Retail Pharmacy:** Visit a participating retail pharmacy and your Anthem identification card is all you need to get full benefits for your outpatient prescription drugs. With your card you can receive up to a 31-day supply of medication from any participating retail pharmacy.
- **Home Delivery Pharmacy Program:** With the Anthem RX Direct Mail Service Pharmacy, you can receive up to a 90-day supply of your maintenance medications (such as medication for high blood pressure or high cholesterol), and your prescription is delivered directly to your home. The program is easy to use and you'll receive simple, step-by-step instructions once you are enrolled.

Your network

Thousands of pharmacies participate in Virginia, including most major chains.* To find the participating pharmacist nearest you:

- Log onto www.anthem.com
- Refer to your printed provider directory
- Call Anthem Member Services

*Pharmacy Management, Anthem Blue Cross and Blue Shield, July 2003

Your Benefits and Discount Services

While your prescription drug plan covers nearly all prescription medications, certain medications require advance approval, a select few require approval if certain amounts are prescribed and some are not covered.

Advance approvals

Some medications, and certain amounts of some medications, require an approval before they are eligible to be covered by your benefits. This approval process is called prior authorization. In general, there are four reasons why a drug might be added to our prior authorization list:

- Patient safety issues
- Request by the employer
- FDA limitations
- Extraordinarily high price

Should you need a prescription for a drug on the prior authorization list, your doctor will handle the entire prior authorization process for you. Here are the medications that require prior authorization:

This list is subject to change

- Acne therapy (Retin-A and Avita if greater than age 35, Protopic)

•Amerge •Axert •Caverject •Edex •Imitrex •Maxalt •Muse •Sporanex •Stadol •Zomig

- Gonadotropin-releasing agents/analogs (Zoladex, Lupron, Lupron Depot, Synarel)
- Growth Hormones (Geref, Genotropin, Humatrope, Norditropin, Nutropin, Protropin, Saizen, Serostim, etc.)
- Interferons (Roferon-A, Intron A, Rebetron, Actimmune, Avonex, Infergen, PEG-Intron)
- Immunoglobulins (Gamimune N, Gammagard, Gammar-IV, Iveegam, Venglobulin, Sandoglobulin)
- Miscellaneous agents (Botox, Myobloc, Gleevec, Lamisil)
- NSAIDs/Cox-II inhibitors (Mobic)
- Respiratory Syncytial Virus prevention (Synagis)
- Rheumatoid Arthritis therapy (Enbrel, Kineret, Remicade)

Your benefits cover a limited quantity of the following drugs. If your prescription calls for a supply greater than the covered amount, your physician may request prior authorization for the additional quantity to be covered:

•Diflucan (150 mg) •Relenza •Tamiflu •Toradol •Viagra •Zithromax

Trust your generics

If you've ever wondered if generics are just as good as brands, rest assured – they are. The standards set by the Food and Drug Administration require that generic drugs be chemically identical to their brand-name counterparts and equal in safety, strength and effectiveness.

Your prescription drug copayments are designed so you'll pay less out-of-pocket when your prescriptions are filled with generic drugs. So for less money, you receive an equally effective medication.

Participating pharmacies will always dispense a generic drug if a generic drug is available. If you or your doctor requests a brand-name drug when a generic is available, you will pay your usual copayment for the brand-name drug plus the difference in price between the brand and generic drug.

Protecting you

Every time you have a prescription filled at a participating pharmacy, your pharmacist helps safeguard your health with an automatic drug-to-drug interaction check. This confidential comparison between the prescription you've requested and prescriptions you've had filled at other participating pharmacies can help avoid unsafe interactions.

It's a special feature available only when you visit participating pharmacies.

About the drug categories

A number of factors are considered when classifying drugs into categories (tiers), including but not limited to:

- the absolute cost of the drug
- the cost of the drug relative to drugs in the same therapeutic class
- the availability of over-the-counter alternatives
- certain clinical and economic factors

Anthem has sole discretion in making tier assignments and reserves the right, also in its sole discretion, to move any prescription drug from one tier to another.

Anthem

Anthem Blue Cross and Blue Shield receives financial credits from drug manufacturers based on total volume of the claims processed for their products utilized by Anthem members. These credits are retained by Anthem as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits. This benefit summary insert is only one piece of your entire enrollment package. Exclusions are in the enrollment brochure.

Your Routine Vision Care and Discount Plan

Your Network – Davis Vision

The network you will use for your routine vision care benefits and discounts is the Davis Vision Network. Your full in-network benefits and discounts are available when you use Davis Vision participating providers. Many participating providers offer complete vision care services while others may offer only partial services such as dispensing eyeglasses or contact lenses. A key on the provider listing shows which services each provider offers.

In-Network Services	YOU PAY
Routine eye care • an annual routine eye exam	**$15**
	YOUR DISCOUNTS
Eyeglass frames, lenses and contacts To complement your routine eye care, visit a Davis Vision participating eye care professional for up to 40% off eyewear, and even greater discounts on many lens options. You'll receive these discounts at your initial visit, and a 20% courtesy discount at each subsequent visit to the same participating provider. Refer to the "eyewear discounts" chart below to see what you'll pay for frames, lenses and contacts.	up to **40% off** frames, lenses and contacts
Laser vision correction surgery If laser vision correction surgery is an option for correcting your vision, you can receive up to a 25% discount on the procedure (or 5% off an advertised sale price, whichever is lower) by using one of the experienced eye surgeons in the Davis Vision Laser Surgery Discount Network.	up to **25% off**
Mail order contact lenses You can register to use LENS 1-2-3® and receive your contact lenses by mail at a savings of up to 50% below the retail price. Call 1-800-LENS123 for complete details on how to order your contact lenses from LENS 1-2-3.	up to **50% off**

Out-Of-Network Services

Should you choose to receive your routine eye exam from an eye care professional not in the Davis Vision network, you will receive a $30 reimbursement to use toward the provider's bill. Eye care and eyewear discounts are available only from eye care professionals in the Davis Vision Network.

You also need to know...

The Davis Vision Network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

Your out-of-pocket expenses related to the vision benefits do not count toward your annual out-of-pocket limit and are never waived, even if your annual out-of-pocket limit is reached.

Anthem KeyCare

Your eyewear discounts

When you visit a Davis Vision participating eye care professional or vision center, you'll pay the discount price for a pair of eyeglasses and/or a supply of contact lenses selected at your initial visit. You'll also receive up to a 20% courtesy discount on additional purchases or subsequent visits to the same provider (except at Wal-Mart Vision Centers where Every Day Low Pricing and special eyewear savings will apply).

Your eyewear discounts

Special eyewear savings at Wal-Mart

These savings can be combined to realize savings on both a pair of eyeglasses and a contact lens purchase made during the initial visit.

Eyewear options	You save
Contact Lenses	$5 off usual and customary
Lenses	$5 off usual and customary
Frames	$5 off usual and customary

Your eyewear discounts for all other Davis Vision providers are as follows:

	You pay	Average retail price	Approximate savings
Frames[1]			
Priced up to $70 retail	$40	Up to $70	43%
Priced above $70 retail	$40 plus 10% off the amount over $70	Over $70	28%
Lenses - Uncoated Plastic[1]			
Single Vision	$35	$50	30%
Bifocal	$55	$75	27%
Trifocal	$65	$90	28%
Lenticular	$110	$160	31%
Lens Options (Add to the price of the lens you select)[1]			
Standard Progressive	$75	$150	50%
Premium Progressive	$125	$200-$300	38%-58%
Polaroid Lenses	$75	$95	21%
High Index Lenses	$55	$95	42%
Glass Lenses	$18	$30	40%
Polycarbonate Lenses	$30	$60	50%
Scratch-resistant Coating	$15	$30-$60	50%-75%
Glare-resistant Treatment	$45	$55	18%
Ultraviolet Coating	$15	$20	25%
Solid Tint	$10	$15	33%
Gradient Tint	$12	$15	20%
Photogrey	$35	$40-$60	12%-42%
Transitions®[1]	$65	$100-$150	35%-57%
Contact Lenses			
Conventional	20% off usual and customary		20%
Disposable/Planned Replacement	10% off usual and customary		10%
Professional Fees (evaluation, fitting, and follow-up care)	15% off usual and customary		15%
Other Products			
Non-prescription Sunglasses	20% off usual and customary		20%
Other Ancillary Products/Solutions	10% off usual and customary		10%

[1]**Special lens designs, materials, powers and frames may require additional cost.**

These eyewear products and eye care services are available to you at these savings as part of a discount program. They are not covered by your plan benefits.

Dependent children are covered until December 31st of the year they turn 23.

Now that you've read about the coverage an Anthem KeyCare plan offers — the benefits, special programs and discount services — it's also important that you take the time to read this section. It outlines who can enroll in your Anthem KeyCare plan, when and how your coverage can change, what's not covered by your plan and how your plan works with any other health care coverage you have.

Who you can cover

You can choose coverage for you alone or family coverage that includes you and any of the following family members:

- your husband or wife
- your unmarried natural children including children you have adopted or are in the process of adopting
- your unmarried stepchildren or children for whom you are the legal guardian if you provide more than one half of their support

Some children have mental or physical challenges that prevent them from living independently. The dependent age limit does not apply to these enrolled children as long as these challenges were present before they reached age 23.

How and when your coverage can be changed

Your Anthem KeyCare coverage can be renewed, cancelled or changed on two different levels. The first is on the employer level, which would impact you and everyone else covered under your employer's plan. The second level impacts your coverage only — including your covered family members — and does not apply to any others covered under your employer's plan.

Special enrollment periods

If you initially state in writing that you are declining to enroll in your group health plan for yourself or your dependents (including your spouse) because you have coverage through another carrier or group health plan, you may be able to enroll yourself and your dependents in this plan if you or your dependents later lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your group administrator.

Anthem KeyCare

1. On the employer level — which impacts you as well as all employees under your employer's plan — your Anthem KeyCare plan can be…

renewed	cancelled	changed	when…
✓			your employer maintains its status as an employer, remains located in our service area, meets our guidelines for employee participation and premium contribution, pays the required health care premiums and does not commit fraud or misrepresent itself.
	✓		after a 31-day grace period, your employer still does not pay the required health care premium (at least a 15-day notice will be given to your employer) or makes a bad payment or your employer can voluntarily cancel coverage by giving us a 30-day advance written notice.
	✓		we decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice) or if we decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		✓	your employer and you received a 30-day advance written notice that the coverage was being changed (services added to your plan or the copayment amounts decreased). Copayments can be increased or services can be decreased only when it is time for your group to renew its Anthem KeyCare coverage.

2. On an individual level — factors that apply to you and covered family members — your Anthem KeyCare plan can be...

renewed	cancelled	when…
✓		you maintain your eligibility for coverage with your employer, pay your required portion of the health care premium and do not commit fraud or misrepresent yourself.
	✓	you purposely give wrong information about yourself or your dependents when you enroll. Cancellation is effective immediately.
	✓	you lose your eligibility for coverage, don't make required payments or make bad payments, commit fraud, are guilty of gross misbehavior, don't cooperate with coordination of benefits recoveries, let others use your ID card, use another member's ID card or file false claims with us. Your coverage will be cancelled after you receive a written notice from us.

When you'll be covered by Anthem KeyCare and another health care plan

Coordination of Benefits (COB) helps our members who are covered by more than one group health plan ensure they receive the benefits to which they are entitled while avoiding overpayment by either carrier. Because current and accurate information is the key to our Coordination of Benefits program, Anthem KeyCare members can expect to receive a COB questionnaire on an annual basis. Timely response to these questionnaires will help avoid delays in claims payment.

When a member is covered by two different group health plans, one is considered primary and the other is considered secondary. The primary carrier is the first to pay the claim and provides reimbursement according to plan allowances; the secondary carrier then provides reimbursement, typically covering the remaining allowable expenses.

Determining the primary versus secondary carrier

The following rules apply when determining which health plan is the primary carrier. The term "participant" is used and means the person who is signing up for coverage:

When a person is covered by 2 group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	✓	
	The plan with COB is		✓
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	✓	
	The plan covering the person as a dependent is		✓
The person is the participant in two active group plans	The plan that has been in effect longer is	✓	
	The plan that has been in effect the shorter amount of time is		✓
The person is an active employee on one plan and enrolled as a COBRA participant	The plan in which the participant is an active employee is	✓	
	The COBRA plan is		✓
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in calendar year (known as the birthday rule) is	✓	
	The plan of the parent whose birthday is later in the the calendar year is		✓
	Note: When the parents have the same birthday, the plan that has been in effect longer is	✓	
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	✓	
	The plan of the other parent is		✓

When a person is covered by 2 group plans, and	Then	Primary	Secondary
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent's plan is	✓	
	The non-custodial parent's plan is		✓
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	✓	
	The plan of the parent whose birthday is later in the calendar year is		✓
	Note: When the parents have the same birthday, the plan that has been in effect longer is	✓	

Medicare coverage is available to certain individuals who are under age 65. Payment coordination with Medicare is shown below:

When a person is covered by Medicare and a group plan, and	Then	Anthem KeyCare is Primary	Medicare is Primary
Is a person who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD-kidney failure)	During the 30-month Medicare entitlement period	✓	
	Upon completion of the 30-month Medicare entitlement period		✓
Is a disabled member who is allowed to maintain group enrollment as an active employee	If the group plan has more than 100 participants	✓	
	If the group plan has fewer than 100 participants		✓
Is the disabled spouse or dependent child of an active full-time employee	If the group plan has more than 100 participants	✓	
	If the group plan has fewer than 100 participants		✓
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement	✓	
	If Medicare had been primary to the group plan before ESRD entitlement		✓

Right of recovery

If health care benefits are inadvertently overpaid, reimbursement for the overpayment will be requested. Your help in the recovery process would be appreciated. We reserve the right to recover any overpayment from:

- any person to or for whom the overpayments were made;
- any health care company; and
- any other organization.

Ins and Outs of Coverage

This list of services and supplies that are excluded from coverage by your health plan will not be covered in any case.

A

- **acupuncture.**

B

- **biofeedback therapy.**

C

- high dose **chemotherapy** and/or high dose radiation, any supporting autologous, allogeneic or syngeneic bone marrow transplants or stem cell rescue and any medical problems that result from them except in limited circumstances. In addition, your coverage does not include benefits for the following:

— high dose chemotherapy with allogeneic stem cell support after a prior failed course of high dose chemotherapy with autologous stem cell support;

— tandem transplants, which are two courses of high dose chemotherapy with allogeneic, autologous or syngeneic stem cell support, which are typically administered at intervals of two to six months, contingent on recovery from prior toxicities; and

— autologous, allogeneic, or syngeneic bone marrow transplants or stem cell rescue together with and when used in conjunction with low dose chemotherapy, and any medical problems that result from them, except allogeneic bone marrow transplants involving the use of low doses of chemotherapy when used to treat certain conditions.

- over the counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags.

- **cosmetic surgery** or **procedures**, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

D

- No **dental services** are provided except for the following:

— medically necessary dental services resulting from an accidental injury, provided that for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem Blue Cross and Blue Shield;

— the cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth;

— the repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face;

— dental services and appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;

— dental services to prepare the mouth for radiation therapy to treat head and neck cancer; or

— covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are provided when it is determined by a licensed dentist, in consultation with the covered persons' treating physician that such services are required to effectively and safely provide dental care.
This exclusion will not apply if your group's coverage includes a dental rider.

• **donor** searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, sibling).

E

• **educational** or teacher services except in limited circumstances.

• **experimental/investigative** procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute.

F

• the following **family planning** services. These include:

— services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;

— drugs used to treat infertility; or

— reversals of sterilization.

• services for palliative or cosmetic **foot** care including:

— flat foot conditions;

— support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;

— foot orthotics;

— subluxations of the foot;

— corns;

— bunions (except capsular or bone surgery);

— calluses;

— care of toenails;

— fallen arches;

— weak feet;

— chronic foot strain; or

— symptomatic complaints of the feet.

H

• routine **hearing care** or hearing aids or exams for these devices except as described in this booklet.

• the following **home care** services:

— homemaker services;

— maintenance therapy;

— food and home delivered meals; or

— custodial care and services.

• the following **hospital** services:

— guest meals, telephones, televisions, and any other convenience items received as part of your inpatient stay;

— care by interns, residents, house physicians, or other facility employees that are billed separately from the facility;

— a private room unless it is medically necessary.

M

• **maternity** benefits for your unmarried dependent children.

• **medical equipment, appliances and devices, and medical supplies** that have both a non-therapeutic and therapeutic use. These include:

— exercise equipment;

— air conditioners, dehumidifiers, humidifiers, and purifiers;

— hypoallergenic bed linens;

— whirlpool baths;

— handrails, ramps, elevators, and stair glides;

— telephones;

— adjustments made to a vehicle;

— foot orthotics;

— changes made to a home or place of business; or

— repair or replacement of equipment you lose or damage through neglect

- services or supplies if they are deemed not **medically necessary** as determined by Anthem at its sole discretion. Nothing in this exclusion shall prevent a member from appealing our decision that a service is not medically necessary.

However, if you receive inpatient or outpatient services that are denied as not medically necessary, the following professional provider services that you receive during your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:

For inpatients

1. services that are rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2. services rendered by your attending provider other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your attending provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your attending provider.

For outpatients – services of pathologists, radiologists and anesthesiologists rendering services in an (i) outpatient hospital setting, (ii) emergency room, or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician.

- the following **mental health services and substance abuse services**:

— inpatient stays for environmental changes;

— cognitive rehabilitation therapy;

— educational therapy;

— vocational and recreational activities;

— coma stimulation therapy;

— services for sexual deviation and dysfunction;

— treatment of social maladjustment without signs of a psychiatric disorder;

How new medical technologies are evaluated

Many of the Anthem KeyCare medical directors and staff actively participate in a number of national health care committees that review and recommend new treatments for coverage. To be approved for coverage, the service or product must have:

- regulatory approval from the Food and Drug Administration;
- been put through extensive research study to find all the benefits and possible harms of the technology;
- benefits that are far better than any potential risks;
- at least the same or better effectiveness as any similar service or procedure already available; and
- been tested enough so that we can be certain it will result in positive results when used in real cases.

— remedial or special education services; or

— inpatient mental health treatments that meet the following criteria:

- more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital;
- group psychotherapy when there are more than 8 patients with a single therapist;
- group psychotherapy when there are more than 12 patients with two therapists;
- more than 12 convulsive therapy treatments during a single admission; or
- psychotherapy provided on the same day of convulsive therapy.

N

- **nutrition** counseling and related services, except when provided as part of diabetes education.

O

- care of **obesity** or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.
- benefits for **organ or tissue transplants**, including complications caused by them, except when they are considered medically necessary, have received preauthorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

P

- **paternity testing**.
- **prescription drug benefit** does not include coverage for:

— over the counter drugs;

— any per unit, per month quantity over the plan's limit;

— drugs used mainly for cosmetic purposes;

— drugs that are experimental, investigational, or not approved by the FDA;

— cost of medicine that exceeds the allowable charge for that prescription;

— drugs for weight loss;

— stop smoking aids;

— therapeutic devices or appliances;

— injectable prescription drugs that are supplied by a provider other than a pharmacy;

— charges to inject or administer drugs;

— drugs not dispensed by a licensed pharmacy;

— drugs not prescribed by a licensed provider;

— any refill dispensed after one year from the date of the original prescription order;

— medicine covered by workers' compensation, Occupational Disease Law, state or government agencies; or

— medicine furnished by any other drug or medical service.

- **private duty nurses** in the inpatient setting.

R

- rest cures, **residential** or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether the member receives active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic services.
- care from institutions that are licensed based solely as **residential treatment** centers, intermediate care facilities, or other non-skilled sub-acute inpatient settings.

S

- **services or supplies** if they are:

— ordered by a doctor whose services are not covered under your health plan;

— care of any type given along with the services of an attending provider whose services are not covered;

— not listed as covered under your health plan;

— not prescribed, performed, or directed by a provider licensed to do so;

— received before the effective date or after a covered person's coverage ends; or

— telephone consultations, charges for not keeping appointments, or charges for completing claim forms.

• **services or supplies** if they are:

— for travel, whether or not recommended by a physician;

— given by a member of the covered person's immediate family;

— provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not you waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted;

— provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;

— received from an employer mutual association, trust, or a labor union's dental or medical department; or

— for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

• **services** for which a charge is not usually made. This includes services for which you would not have been charged if you did not have health care coverage.

• **services or benefits** for:

— amounts above the allowable charge for a service;

— self administered services or self care;

— self help training; or

— biofeedback, neurofeedback, and related diagnostic tests.

• benefits for surgeries for **sexual dysfunction**. In addition, your coverage does not include benefits for services for **sex transformation**. This includes medical and mental health services.

• the following **skilled nursing** facility stays:

— treatment of psychiatric conditions and senile deterioration; or

— facility services during a temporary leave of absence from the facility.

- benefits for services related to **smoking cessation**, including stop smoking aids or services of stop smoking clinics.

- **spinal manipulations** or other manual medical interventions for an illness or injury other than musculoskeletal conditions.

T

- the following **therapies**:

— physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services;

— group speech therapy;

— group physical therapy;

— recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

V

- the following **vision services**:

— services for radial keratotomy and other surgical procedures to correct nearsightedness and/or farsightedness. This type of surgery includes keratoplasty and Lasik procedure;

— services for vision training and orthoptics; or

— any other vision services not specifically listed as covered.

W

- services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the covered person reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.

The most detailed description of benefits, exclusions and restrictions can be found in the following group policies and endorsements which can be requested by calling Member Services at 1-800-451-1527.

PP-INTRO (1/04), P-TOC (1/04), P-SB1 (1/04), P-SB2 (1/04), P-SB3 (1/04), P-SB4 (1/04), P-WORKS (1/04), P-COVERED (1/04), P-EXCL (1/04), P-CLAIMS (1/04), P-ENR (1/04), P-ENDS (1/04), P-RIGHTS (1/04), P-DEF (1/04), P-XH-A (1/04), P-EXH-A-1 (1/04)

This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem KeyCare offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern.

Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area.

For more information, please call Member Services at 1-800-451-1527 or 358-1551 from the Richmond calling area.

Member Services may also be contacted at
P.O. Box 27401
Richmond, VA 23279-7401

Visit us on the internet at www.anthem.com.

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